		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041574

Facility Name: MATTOON HEALTH CARE CENTER

Address: 2121 South Ninth Street (Number) Mattoon (City) 61938 (Zip Code)

County: Cole

Telephone Number: 217-235-7138 **Fax #** 217-235-7140

IDPA ID Number: 431588535008

Date of Initial License for Current Owners: 3/8/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kathy Herman, HP/ Mgmt Services Inc. **Telephone Number:** 770-870-2838

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from May 1, 2001 to April 30, 2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 11/15/02 (Date)
(Type or Print Name) Linda Rossi
(Title) Corporate Secty-HP Management Services Inc. Facility Mgmt Co.

Paid Preparer

(Signed) 11/15/02 (Date)
(Print Name and Title) Kathy Herman, Reimbursement Supervisor
(Firm Name & Address) HP\ Management Services Inc., 950 N Pointe Pkwy Ste 100 Alpharetta, GA 30005
(Telephone) 770-870-2838 Fax # 770-870-1333

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	148	Skilled (SNF)	148	54,020	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	148	TOTALS	148	54,020	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,571	199	3,547	5,317	8
9	SNF/PED					9
10	ICF	19,312	11,550	528	31,390	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,883	11,749	4,075	36,707	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.95%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
EMPLOYEE GUEST MEALS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/8/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/8/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 3,547

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: APRIL 30 Fiscal Year: APRIL 30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 **Report Period Beginning:** May 1, 2001 **Ending:** April 30, 2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	178,235	14,554	8,728	201,517	544	202,061		202,061			1
2	Food Purchase		172,142		172,142	(1,049)	171,093	(7,928)	163,165			2
3	Housekeeping	82,923	23,068		105,991		105,991		105,991			3
4	Laundry	45,756	9,925		55,681		55,681		55,681			4
5	Heat and Other Utilities			128,066	128,066		128,066	(3,730)	124,336			5
6	Maintenance	40,679	7,760	28,786	77,225		77,225		77,225			6
7	Other (specify):* **Waste Removal**			4,694	4,694	1,792	6,486		6,486			7
8	**TOTAL General Services**	347,593	227,449	170,274	745,316	1,287	746,603	(11,658)	734,945			8
	B. Health Care and Programs											
9	Medical Director			4,845	4,845		4,845		4,845			9
10	Nursing and Medical Records	1,380,528	70,889	18,719	1,470,136	(20,317)	1,449,819	(31,710)	1,418,109			10
10a	Therapy		105,629	510,279	615,908	(18,716)	597,192		597,192			10a
11	Activities	30,705	2,873	2,234	35,812	553	36,365		36,365			11
12	Social Services	44,557		2,234	46,791		46,791		46,791			12
13	Nurse Aide Training											13
14	Program Transportation			1,789	1,789		1,789		1,789			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,455,790	179,391	540,100	2,175,281	(38,480)	2,136,801	(31,710)	2,105,091			16
	C. General Administration											
17	Administrative	63,598			63,598	(7,596)	56,002		56,002			17
18	Directors Fees											18
19	Professional Services			372,611	372,611	736	373,347		373,347			19
20	Dues, Fees, Subscriptions & Promotions			22,553	22,553	(138)	22,415	(4,550)	17,865			20
21	Clerical & General Office Expenses	92,829	15,110	85,167	193,106	(5,003)	188,103	(23,192)	164,911			21
22	Employee Benefits & Payroll Taxes			290,455	290,455	3,503	293,958		293,958			22
23	Inservice Training & Education			1,607	1,607		1,607		1,607			23
24	Travel and Seminar			12,525	12,525	(495)	12,030	(6,061)	5,969			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			204,070	204,070		204,070		204,070			26
27	Other (specify):* **Bad Debt**			70,383	70,383		70,383	(70,383)				27
28	**TOTAL General Administration**	156,427	15,110	1,059,371	1,230,908	(8,993)	1,221,915	(104,186)	1,117,729			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,959,810	421,950	1,769,745	4,151,505	(46,186)	4,105,319	(147,554)	3,957,765			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MATTOON HEALTH CARE CENTER #0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			39,024	39,024		39,024		39,024			30
31	Amortization of Pre-Op. & Org.			244	244		244		244			31
32	Interest			239,743	239,743	5,381	245,124	(87,214)	157,910			32
33	Real Estate Taxes			101,450	101,450		101,450		101,450			33
34	Rent-Facility & Grounds			217,431	217,431		217,431	(217,431)				34
35	Rent-Equipment & Vehicles			19,520	19,520	(312)	19,208		19,208			35
36	Other (specify):*											36
37	**TOTAL Ownership**			617,412	617,412	5,069	622,481	(304,645)	317,836			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			360	360		360		360			38
39	Ancillary Service Centers		211,958	8,718	220,676	40,306	260,982		260,982			39
40	Barber and Beauty Shops		262		262		262		262			40
41	Coffee and Gift Shops					1,049	1,049	(1,049)				41
42	Provider Participation Fee			80,512	80,512		80,512		80,512			42
43	Other (specify):* LAB			10,306	10,306	(238)	10,068		10,068			43
44	**TOTAL Special Cost Centers**		212,220	99,896	312,116	41,117	353,233	(1,049)	352,184			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,959,810	634,170	2,487,053	5,081,033		5,081,033	(453,248)	4,627,785			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,928)			4
5	Telephone, TV & Radio in Resident Rooms	(3,730)			5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(87,214)			10
11	Discounts, Allowances, Rebates & Refunds	(21,515)			11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(10,195)			16
17	Non-Care Related Fees	(1,215)			17
18	Fines and Penalties	(22,997)			18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,211)			24
25	Fund Raising, Advertising and Promotional	(4,550)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(244,693)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (453,248)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (453,248)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops	X		1,049	2	40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program	X		40,306	10, 10A,20	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 41,355		47

STATE OF ILLINOIS

MATTOON HEALTH CARE CENTER

ID# 0041574

Report Period Beginning: May 1, 2001

Ending: April 30, 2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	OTHER MISC REVENUE	$ (194)	21	1
2	EMPLOYEE MEALS REVENUE	(7,928)	2	2
3	CABLE TV REVENUE	(3,730)	5	3
4	NONANCILLARY PERSONAL CARE REV	(10,195)	10	4
5	CONCESSIONS REVENUE	(1,049)	41	5
6	INTEREST INCOME	(68,021)	32	6
7	INTEREST INCOME-INTERCO	(19,193)	32	7
8	DEBT FORGIVENESS	(21,515)	10	8
9	ADVERTISING COMMUNITY AWARENESS	(2,309)	20	9
10	BAD DEBT	(49,211)	27	10
11	RESIDENT EXPENSE	(1,215)	27	11
12	PRIOR YEAR EXPENSE	(19,957)	27	12
13	PENALTIES	(1,976)	21	13
14	PENALTIES-OTHER	(21,021)	21	14
15	PROMOTIONAL ADVERTISING	(142)	20	15
16	NON ALLOWABLE DUES	(15)	20	16
17	NON ALLOWABLE DUES	(30)	20	17
18	CHAMBER OF COMMERCE	(663)	20	18
19	NON ALLOWABLE SUBSCRITIONS	(30)	20	19
20	NON ALLOWABLE PERMITS	(30)	20	20
21	NON ALLOWABE ADVERT PROMOTIONS	(1,332)	20	21
22	NON ALLOWABLE TRAVEL	(6,061)	24	22
23	NON ALLOWABLE BUILDING LEASE	(217,431)	34	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(453,248)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 **Report Period Beginning:** May 1, 2001 **Ending:** April 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,928)	0	0	0	0	0	0	0	0	0	0	(7,928)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,730)	0	0	0	0	0	0	0	0	0	0	(3,730)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,658)	0	0	0	0	0	0	0	0	0	0	(11,658)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(31,710)	0	0	0	0	0	0	0	0	0	0	(31,710)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(31,710)	0	0	0	0	0	0	0	0	0	0	(31,710)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,551)	0	0	0	0	0	0	0	0	0	0	(4,551)	20
21	Clerical & General Office Expenses	(23,191)	0	0	0	0	0	0	0	0	0	0	(23,191)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,061)	0	0	0	0	0	0	0	0	0	0	(6,061)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(70,383)	0	0	0	0	0	0	0	0	0	0	(70,383)	27
28	**TOTAL General Administration**	(104,186)	0	0	0	0	0	0	0	0	0	0	(104,186)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(147,554)	0	0	0	0	0	0	0	0	0	0	(147,554)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 **Report Period Beginning:** May 1, 2001 **Ending:** April 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(87,214)	0	0	0	0	0	0	0	0	0	0	(87,214)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(217,431)	0	0	0	0	0	0	0	0	0	0	(217,431)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(304,645)	0	0	0	0	0	0	0	0	0	0	(304,645)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(1,049)	0	0	0	0	0	0	0	0	0	0	(1,049)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,049)	0	0	0	0	0	0	0	0	0	0	(1,049)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(453,248)	0	0	0	0	0	0	0	0	0	0	(453,248)	45

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LISTING: HUNTER CARE CENTER, INC.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		NOT APPLICABLE	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: ril 30, 2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: No Longer in Business
Street Address: During this Cost Reporting
City / State / Zip Code: Period -
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		NOT APPLICABLE				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC		X	MORTGAGE	$51,900.00	4/14/99	$ 8,122,000	$ 8,065,870	5/1/03	0.0825	$ 155,700	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DVI		X	WORKING CAPITAL	N/A		527,903	837,788		FLOATING	53,292	6
7	INTERCO INT/HP INSUR		X	INSURANCE & WKG CAP	N/A					FLOATING	65,127	7
8	AMERICAN HEALTHTECK		X	INTEREST ON SFTWR PUR	N/A						120	8
9	TOTAL Facility Related				$51,900.00		$ 8,649,903	$ 8,903,658			$ 274,239	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,649,903	$ 8,903,658			$ 274,239	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	66,319	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	(66,319)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	167,769	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	101,450	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	146,846	8
1998	96,857	9
1999	98,037	10
2000	100,967	11
2001	55,340	12

Property taxes due for 2001 $55,340 Total Accrual $167,769
Property taxes due from 2000 $100,967
Property taxes due from 1999 $11,462

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MATTOON HEALTH CARE CENTER COUNTY Cole

FACILITY IDPH LICENSE NUMBER 0041574

CONTACT PERSON REGARDING THIS REPORT Marc Rosen, Director of Tax

TELEPHONE (770) 619-0866 ext. 286 FAX #: (770) 619-0262

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-1-00922-000	Land & Building	$ 55,339.60	$ 55,339.60
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 55,339.60	$ 55,339.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,372 B. General Construction Type: Exterior Masonary Frame Steel Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY GROUNDS	5 ACRES	1996	$ 94,000	1
2					2
3	TOTALS	#VALUE!		$ 94,000	3

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	148		1996	1971	$ 3,712,783	$ 23,205	40	$ 23,205	$ 0	$ 565,087	4
5			1996		370,000	4,625	20	4,625		100,208	5
6											6
7											7
8											8
	Improvement Type**										
9	Roof Repair			1996	6,640	277	5	277		6,640	9
10	Outlet Strip Vent Equipment			1996	1,900	48	5	48		966	10
11	Vinyl Tyle			1996	1,753	44	5	44		876	11
12	Wall Material Remodeled			1996	1,672	28	5	28		530	12
13	Flooring			1996	759	19	5	19		358	13
14	Carpet In Administrative Areas			1996	701	18	5	18		327	14
15	RestoreWest Wing Rotunda			1996	4,821	121	5	121		2,270	15
16	Door Frame Wall Guards			1996	4,433	74	5	74		1,368	16
17	Wall Borders			1997	500	25	5	25		458	17
18	Wallpaper and Labor			1997	1,360	68	5	68		1,246	18
19	Carpet for Rotunda			1997	6,600	165	5	165		3,024	19
20	Wallpaper for Rotunda			1997	1,964	70	5	70		1,297	20
21	Flooring			1997	3,119	111	5	111		2,116	21
22	Tile			1997	950	24	5	24		420	22
23	Dryer Installation			1997	3,822	137	5	137		2,412	23
24	Vinyl Bass/Trans Strips			1997	237	6	5	6		108	24
25	Windows (3)			1997	310	8	5	8		126	25
26	Air Conditioning Unit Repairs			1997	363	18	5	18		297	26
27	Switch & Heater Elements			1997	1,273	32	5	32		493	27
28	Walk In Cooler Repair			1999	2,432	203	5	203		1,554	28
29	Heating Repairs			1999	1,567	131	5	131		827	29
30	Adjust Assets and Accum Depr to B/S 2000			2000	2,549	127	5	127		1,863	30
31	Carpeting			2001	18,868	472	3	472		786	31
32	Carpeting			2001	15,635	651	10	651		651	32
33	Fire Equipment			2001	1,514	25	5	25		25	33
34	Door			2001	2,100	35	5	35		35	34
35	Adjustment to Dep Exp			2001		1,491	20	1,491		1,491	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,170,625	$ 32,256		$ 32,256	$ 0	$ 697,860	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 262,925	$ 6,726	$ 6,726	$		$ 177,323	71
72	Current Year Purchases	5,020	42	42			42	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 267,945	$ 6,768	$ 6,768	$		$ 177,365	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,532,570	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 39,024	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 39,024	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 875,225	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 19,520 Description: VARIOUS-SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 200

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THIS FACILITY HIRES ONLY "CERTIFIED" NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$	4,210	$ 76,300	$	4,210	$ 76,300	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		751	12,961		751	12,961	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		4,688	117,381		4,688	117,381	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts		5,942		157,104	5,942	157,104	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program			20,807		18,954	17,203		56,964	12
13	Other (specify): Resp Ther, Lab	10A-3, 43-3			11,397	284,921	105,629 10,068	11,397	390,550 10,068	13
14	TOTAL			$ 20,807	26,988	$ 510,517	$ 290,004	26,988	$ 821,328	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of April 30, 2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (56,692)	$	1
2	Cash-Patient Deposits	7,683		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,760,740		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(18,012)		6
7	Other Prepaid Expenses	854		7
8	Accounts Receivable (owners or related parties)	338,145		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,032,718	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	94,000		13
14	Buildings, at Historical Cost	4,170,626		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	281,484		16
17	Accumulated Depreciation (book methods)	(875,537)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,310		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(244)		20
21	Restricted Funds	(13)		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,677,626	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,710,344	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (4,105,603)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,683		28
29	Short-Term Notes Payable	945,660		29
30	Accrued Salaries Payable	99,064		30
31	Accrued Taxes Payable (excluding real estate taxes)	108,564		31
32	Accrued Real Estate Taxes(Sch.IX-B)	201,767		32
33	Accrued Interest Payable	1,122,895		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Lease			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (1,619,970)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,065,870		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,065,870	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,445,900	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (735,556)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,710,344	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (726,804)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (726,804)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(226,194)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **ROUNDING**	11	15
16	Other (describe) **ELIM ACCR. BLDG LSE LIABILITY**	217,431	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (8,752)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (735,556)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,201,236	1
2	Discounts and Allowances for all Levels	354,011	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,555,247	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	111,563	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 111,563	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,049	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,928	14
15	Telephone, Television and Radio	3,730	15
16	Rental of Facility Space		16
17	Sale of Drugs	4,530	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,065	19
20	Radiology and X-Ray		20
21	Other Medical Services	49,803	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 79,105	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	87,214	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 87,214	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Debt Forgiveness, Misc Revenue	21,710	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,710	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,854,839	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	745,316	31
32	Health Care	2,175,281	32
33	General Administration	1,230,908	33
	B. Capital Expense		
34	Ownership	617,412	34
	C. Ancillary Expense		
35	Special Cost Centers	231,604	35
36	Provider Participation Fee	80,512	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,081,033	40
41	**Income before Income Taxes (line 30 minus line 40)****	(226,194)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (226,194)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,358	2,620	$ 63,428	$ 24.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,434	11,517	194,721	16.91	3
4	Licensed Practical Nurses	27,888	30,477	441,677	14.49	4
5	Nurse Aides & Orderlies	68,556	74,921	653,720	8.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,637	4,593	30,705	6.69	10
11	Social Service Workers	3,438	3,913	44,557	11.39	11
12	Dietician	21,231	23,192	178,235	7.69	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,786	4,142	40,679	9.82	17
18	Housekeepers	10,414	11,758	82,923	7.05	18
19	Laundry	6,795	7,633	45,756	5.99	19
20	Administrator	2,028	2,367	63,598	26.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,739	9,032	92,829	10.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,124	3,465	26,982	7.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,428	189,630	$ 1,959,810 *	$ 10.33	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	200	$ 8,728	1-3	35
36	Medical Director		4,845	9-3	36
37	Medical Records Consultant	54	2,254	10-3	37
38	Nurse Consultant	3	967	10-3	38
39	Pharmacist Consultant			39-3	39
40	Physical Therapy Consultant			10A-3	40
41	Occupational Therapy Consultant			10A-3	41
42	Respiratory Therapy Consultant			10A-3	42
43	Speech Therapy Consultant			10A-3	43
44	Activity Consultant	42	2,234	11-3	44
45	Social Service Consultant	42	2,234	12-3	45
46	Other(specify)				46
47	UTILIZATION REVIEW		5,345	10-3	47
48					48
49	TOTAL (lines 35 - 48)	341	$ 26,607		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NAOMI GATES			$ 56,002
BENEFITS RECLASSED			7,596
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,598

B. Administrative - Other

Description	Amount
	$
NOT APPLICABLE	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
AMERICAN HEALTHTECH	SOFTWARE SERV.	$ 1,484
BRAINARD LAW OFFICES	LEGAL	334
DVI ENTRIES	RCVBL FIN	5,380
HP MGMT SVCS	FACILITY MGMT	331,203
KOMADA & GEISLER	LEGAL	1,000
LONG ALDRIDGE & NORM	LEGAL	24,785
NELSON MULLINS	LEGAL	6,587
PAYDAY USA	PAYROLL PROC	1,723
DIRT CHEAP SOFT	SOFTWARE SERV.	115
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 372,611

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,640
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	18,267
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
ALL PAYROLL TAXES	179,399
OTHER EMPLOYEE BENEFITS	3,652
TOTAL (agree to Schedule V, line 22, col.8)	$ 293,958

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NOT APPLICABLE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 295
Advertising: Employee Recruitment	4,083
Health Care Worker Background Check	2,810
(Indicate # of checks performed 103)	
FACILTY SIGNAGE	795
ILLINOIS HEALTH CARE DUES	9,754
INDUSTRY SUBSCR/DUES	128
PROMOTIONAL ADVERTISING	4,550
Less: Public Relations Expense	( )
Non-allowable advertising	(4,550)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,865

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,996
OUT-OF -STATE MEALS	952
In-State Travel	5,353
IN STATE MEALS	835
Seminar Expense	895
Entertainment Expense	(6,062)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,969

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	NOT APPLICABLE		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: May 1, 2001 Ending: April 30, 20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL. HEALTH CARE ASSOC $9,754**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,451** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **80,512**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES/GUEST** Indicate the amount. $ **8,977**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES-ATTACHED-50 MILES IL**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.